



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
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DEPARTMENT OF HUMAN SERVICES  
EUGENE I. GESSOW, DIRECTOR

October 17, 2008

## GENERAL LETTER NO. 16-J-25

ISSUED BY: Bureau of Protective Services,  
Division of Child and Family Services.

SUBJECT: Employees' Manual, Title 16, Chapter J, ***IN-HOME HEALTH-RELATED CARE SERVICES***, Title page, revised; Contents (page 1), revised; pages 1 through 35, revised; and pages 36 through 39, new.

### Summary

The chapter is completely reformatted. Text changes have to do with forms, as follows:

- ◆ Form 470-2927 or 470-2927(S), *Health Services Application*, is available to the public on the Department's web page. The *Health Services Application* is no longer used for financial eligibility reviews.
- ◆ There is a new form, 470-3118 or 470-3118(S), *Medicaid Review*, which is now used for financial eligibility reviews instead of the *Health Services Application*. The income maintenance computer system automatically issues the *Medicaid Review* to the client at the time of review.
- ◆ Form 470-0506, *Service Report*, which is used to communicate with income maintenance, is now available in Outlook as a template.
- ◆ Form 470-0583, *Individual Client Case Plan*, has been updated and added to 16-J-Appendix and Outlook. The instructions have also been updated.
- ◆ Form 470-0672, *Provider Health Assessment*, has been added to the Department's web page.
- ◆ Form 470-0636, *Provider Agreement*, has been added to Outlook and to the Department's web page.
- ◆ Form 470-0602 or 470-0602(S), *Notice of Decision: Services*, has been added to Outlook.

### Effective Date

Upon receipt.

### **Material Superseded**

Remove the entire Chapter J from Employees' Manual, Title 16, and destroy it. This includes the following pages:

<u>Page</u>	<u>Date</u>
Title page	November 29, 1994
Contents (page 1)	January 4, 2008
Contents (page 2)	February 10, 1998
1	November 29, 1994
2-4	December 15, 2006
4a	February 10, 2004
5, 6	April 24, 2001
7	December 15, 2006
8, 9	April 24, 2001
10, 11	November 29, 1994
12	April 24, 2001
13	December 30, 2005
14, 15	January 4, 2008
16, 17	April 14, 2006
18	February 26, 2002
19-23	September 23, 2005
24, 24a, 25	October 26, 1999
26	September 23, 2005
27-29	January 4, 2008
30	December 26, 2002
31	April 24, 2001
32	December 30, 2005
33-35	July 23, 2002

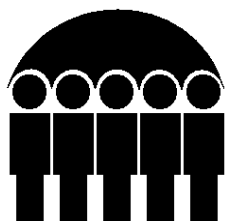
### **Additional Information**

Refer questions about this general letter to your area service administrator.

Revised October 17, 2008

Employees' Manual  
Title 16  
Chapter J

# **IN-HOME HEALTH-RELATED CARE SERVICES**



Iowa  
Department  
of  
Human Services

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## **Chapter Overview**

In-home health-related care is a State Supplementary Assistance program to:

- ◆ Provide health care in the home
- ◆ Prevent out-of-home placement
- ◆ Preserve independent self-care

This program provides health care to a person, of any age, in the person's own home. The person must require health care because of a mental or physical challenge. The services are approved by a physician and supervised by a registered nurse.

The state supplements the person's income to allow the person to pay for the needed services. (The state does not purchase the services directly.) The cost of the services must be below a specified limit but above what the person is determined able to pay.

## **Legal Basis**

Iowa Code Chapter 217 governs the establishment, purposes, and general duties of the Department of Human Services.

Iowa Code Chapter 249 provides that State Supplementary Assistance payments may be made to an eligible person receiving "nursing care in his own home, certified by a physician as being required, so long as the cost of the nursing care does not exceed standards established by the Department."

Iowa Administrative Code 441, Chapter 177, "In-Home Health-Related Care," establishes the rules for the program. Chapters 50, 51, and 52 establish the rules for application, eligibility, and payment for State Supplementary Assistance.

## **Chapter Organization**

This chapter provides workers who will be using the in-home health-related care (IHHRC) program with direction to in relation to:

- ◆ [Determining eligibility](#)
- ◆ [Planning services](#)
- ◆ [Requesting certification](#)
- ◆ [Processing payments](#)
- ◆ [Monitoring and changing services](#)
- ◆ [Termination of services](#)

## **List of Requirements**

**Legal reference:** 441 IAC 177 and 441 IAC 50

### **Application and Assessment**

#### Medical Eligibility

- ◆ Person must be under a physician's care.
- ◆ Care must be supervised by a registered nurse.
- ◆ Person must require health care or personal care.

#### Financial Eligibility (Determined by income maintenance (IM) worker)

- ◆ Person's income must be under the current Supplemental Security Income (SSI) standard plus the current maximum IHHRC payment.
- ◆ Help the client complete form 470-2927 or 470-2927(S), *Health Services Application*, if the client requests assistance. The IM worker may provide this form to the client or the client can print it from the DHS web page.
- ◆ Send the application to the IM worker along with form 470-0506, *Service Report*, requesting the amount of client participation.

NOTE: The signed application form in the IM case file serves as the application for both medical and service components of the program. You do not have to keep a copy of the application form in your case file.

- ◆ If the person's income is below the SSI benefit amount, refer the person to apply for SSI. (The person is eligible for IHHRC when IM is notified of the person's SSI eligibility.)

### Opening Case

- ◆ Have the client sign form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, for the registered nurse.
- ◆ Send signed form 470-3951 or 470-3951(S) to the registered nurse with a request for the physician's plan of care and the nurse's provider instructions.
- ◆ Have the provider sign form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*.
- ◆ Give a copy of signed form 470-3951 or 470-3951(S) to the provider along with form 470-0672, *Provider Health Assessment*, to be completed by the physician.
- ◆ Open SRS: goal 4 or P, service A39, eligibility code 10, 20, or 60.

### Approval

- ◆ Receive Form 470-0506, *Service Report*, indicating client participation, and IM *Notice of Decision*, completed except for date, from the IM worker:
- ◆ Receive physician's plan of care and health provider instructions from the nurse
- ◆ Receive completed *Provider Health Assessment* from the provider.
- ◆ When you have these items, complete form 470-0636, *Provider Agreement*, with the client and the provider.
- ◆ Explain billing procedures, responsibilities, and limitations of the program to the client and provider.
- ◆ Discuss termination procedures and time limits with the client and the provider.
- ◆ Write the case plan using form 470-0583, *Individual Client Case Plan*.

### **Approval (Cont.)**

- ◆ Mail all copies of *Provider Agreement*, and a copy of the case plan, including health care plan, to service area manager (or designee) for approval and certification.
- ◆ When the service area manager (or designee) returns the signed *Provider Agreement*, file one copy and mail one each to client and provider, along with the IM *Notice of Decision* with date added and 470-0602, *Notice of Decision: Services*, approving service.
- ◆ Before sending copies of the *Provider Agreement* to the client and provider, use black marker pen to delete the client's Social Security number.
- ◆ Give each provider an adequate supply of form 470-0648, *Statements of Services Rendered*, and self-addressed stamped envelopes to mail to you at the end of each month.
- ◆ To generate a medical card, send the IM worker form 470-0506, *Service Report*, with "Services Approved" marked, and copies of both service and IM *Notices of Decision*.
- ◆ Add service A60 and B98 (with beginning date and agreement number) on SRS. Remove A39 from SRS, unless monthly visits will continue.
- ◆ Enter provider information on the POSS System.

### **Case Maintenance**

#### **Monthly Billing**

- ◆ Complete forms 470-0020, *Purchase of Service Provider Invoice*, and 470-0648, *Statement of Services Rendered*, submitted by client.
- ◆ Enter invoice information on line onto the POSI screen.
- ◆ Attach *Statement of Services Rendered* to *Purchase of Service Provider Invoice* and place in case file.



Bimonthly Review	The supervising nurse obtains an updated physician's plan of service, reviews the nursing plan, and provides an updated nursing plan for the provider.
Quarterly Review	Review entire care plan at least once every three months.
Annual Review	<ul style="list-style-type: none"><li>◆ Review and reassess all eligibility factors</li><li>◆ Assist the client in completing form 470-3118 or 470-3118(S), <i>Medicaid Review</i>, if the client is unable to complete or get help from family or provider. The IM worker sends this form to the client when it is time for the review.</li><li>◆ Remind the client to obtain the required annual physician's physical examination.</li><li>◆ Have the client sign a current form 470-3951, <i>Authorization to Obtain or Release Health Care Information</i>, for the registered nurse.</li><li>◆ Request a copy of updated health care plan and physician's report from the nurse.</li><li>◆ Have the provider sign a current form 470-3951, <i>Authorization to Obtain or Release Health Care Information</i>.</li><li>◆ Obtain a new <i>Provider Health Assessment</i>, form 470-0672, from provider.</li><li>◆ Complete a new <i>Provider Agreement</i>, form 470-0636, if one has not been completed within the past year. Enter new effective date on the Purchase of Service System (POSS).</li><li>◆ Send <i>Notice of Decision: Services</i>, form 470-0602 or 470-0602(S).</li></ul>

Other

- ◆ Update the Service Reporting System (SRS).
- ◆ Be sure to notify nurse of any changes.
- ◆ When provider changes, terminate Provider Agreement and repeat provider-related steps of approving a case.
- ◆ Be sure to send 470-0506, Service Report, to notify the IM worker of any changes, such as case termination, and (note reason).

## **Determining Eligibility**

**Legal reference:** 441 IAC 177.4(249)

There are three requirements that a person must meet to be eligible for in-home health-related care. They are:

- ◆ The person must be eligible for SSI in every respect except income.
- ◆ The person must be certified by a physician as:
  - Needing specific health care services, and
  - Requiring part time or intermittent professional services that can be provided on an in-home basis which meet specific needs caused by physical or mental limitations.
- ◆ The person must be living in the person's own home.

NOTE: "Own home" means a person's house, apartment, or other living arrangement intended for single or family residential use. A person is considered to be living in the person's own home even though the person may be sharing the household of another. Such arrangements may be temporary or permanent and may be established for the purpose of providing health care.

Instructions for determining eligibility are divided into four sections:

- ◆ [Communicating with income maintenance](#)
- ◆ [Taking applications](#)
- ◆ [Pending applications](#)
- ◆ [Assessing services needs](#)

### **Communicating with Income Maintenance**

You will be communicating with the income maintenance (IM) worker on a regular basis while you are determining eligibility and every time something changes in the client's situation.

Use form 470-0506, *Service Report*, to communicate with the IM worker. See [16-J-Appendix](#) for a sample of this form. You can print this form from the Appendix or complete the form using the template in Outlook.

Examples of times you will use the *Service Report* to communicate with IM are when:

- ◆ You have a new application.
- ◆ Payment for services has been approved.
- ◆ The client's living arrangements have changed.
- ◆ The client has died.
- ◆ The client is no longer receiving the service.

Examples of times when the IM worker would use the *Service Report* to communicate with you are when:

- ◆ Client participation has been determined.
- ◆ The client becomes eligible to receive Medicaid.
- ◆ The client's income has increased or decreased.
- ◆ The client participation has increased or decreased.
- ◆ The client's living arrangements have changed.
- ◆ The client is ineligible for services.

Usually, but not always, you will attach another document to the *Service Report*, such as a new application for State Supplementary Assistance.

## **Taking Application**

**Legal reference:** 441 IAC 177.4(10)

The client, or a responsible person acting on behalf of the client, shall apply for services at the local office of the Department. A Department income maintenance (IM) worker is responsible for determining financial eligibility. Either the Department service worker or the Department IM worker can take the application.

Form 470-2927 or 470-2927(S), *Health Services Application*, is the application for both medical and service components of the in-home health-related care program. The signed application is kept in the IM case file. It is not necessary for you to have a copy of the *Health Services Application* in your case file.

NOTE: The *Health Services Application* serves the purpose of the *Application for All Social Services*, form 470-0615 or 470-0615(S). It is not necessary for the client to sign the *Application for All Social Services* also.

If you receive the application before the IM worker, send it to the IM worker with the *Service Report*, form 470-0506, as soon as possible. You will receive notice from the IM worker on the *Service Report* as to whether the client is eligible and if client participation is required.

If the client's income is above SSI standards, the IM worker determines the amount of countable income and resources based on policies in 6-B, [Resources](#), and 8-E, [INCOME POLICIES FOR SSI-RELATED COVERAGE GROUPS](#).

Countable income may be from any source: Veterans Administration, Railroad Retirement, Social Security, pension, interest, farm, etc.

If income is below SSI standards and the client is not receiving SSI, it is essential that the client, the client's legal representative, or a concerned party immediately complete an application at the Social Security Administration office, so SSI eligibility can be established. (Application for other benefits is an eligibility factor for State Supplementary Assistance.)

### **Pending Applications**

**Legal reference:** 441 IAC 177.4(10)

Complete the eligibility determination within 30 days from the date of the application, unless one or more of the following conditions exist:

- ◆ An application for Supplemental Security Income (SSI) benefits is pending.
- ◆ You have not received information for a reason that is beyond the control of the client or the Department.
- ◆ The application is pending due to the disability determination process performed through the Department.
- ◆ The application is pending because form 470-0636, *Provider Agreement*, has not been completed and completion is beyond control of the client.

NOTE: If a provider cannot be located within 60 days from the date of application, close the service case unless the client is receiving other services. The case may be reopened when a provider is located.

### **Assessing Service Needs**

**Legal reference:** 441 IAC 177.4(1); 441 IAC 177.4(2)

In-home health-related care can be provided only when other existing programs cannot meet the client's needs. A person cannot receive the same service from in-home health-related care and another program at the same time. A person who is eligible for more than one program that can provide the same service must select one of the programs for that service.

For the assessment process, complete form 470-0555, *Services Reporting System*, using goal 4 (self-sufficiency), objective P (preventing out-of-home placement), and service code A-39 (adult support).

If an in-home health-related care program is established, enter a secondary service B98 (in-home health). Remove service code A39 (adult support), unless monthly visits are planned.

See [XIV-A](#) for instructions for use of form 470-0555, *Services Reporting System*.

1. Make an initial assessment of the client's physical and emotional health care needs and protective needs, based on all available information including information from other professionals (e.g., physician, public health nurse).
2. Make the initial determination that the client's needs can be met by an in-home program, and cannot be adequately met by other community programs, including:
  - ◆ Homemaker-health aide program
  - ◆ Visiting nurse services
  - ◆ Chore service
  - ◆ Medicaid waiver programs
  - ◆ Service organizations
  - ◆ County-funded programs
3. Consult the physician or arrange for the supervising nurse to consult the physician to determine the health care needs of the client. The physician must make the determination of whether or not the client needs the service and whether or not the client's health care needs can be met with this service.
4. Consult with supervising nurse regarding the personal, nursing, and medical care required by the client, the qualifications of the provider, and the amount of supervision the nurse will provide.
5. Assist the client and family with obtaining the necessary health care services, as stated in the health care plan, registered nurse, licensed practical nurse, homemaker-home health aide, or volunteers (family or otherwise) to be trained by a professional, either from another agency or private providers.
6. Help the client inform these persons about how the program will operate, including payment procedures, and provide overall coordination of the health care services with other services being provided to the client, e.g., chore service, mobile meals, homemaker, etc.
7. Obtain a transfer form describing the client's current care plan, to be provided to the registered nurse supervising the in-home care plan, if the client is being transferred from a hospital or nursing facility.

## **Planning Services**

This section covers the actions necessary to move from the service assessment to a plan for using the in-home health care program to meet the client's assessed needs. It is organized in the following parts:

- ◆ [Available services](#)
- ◆ [Health care plan](#)
- ◆ [Case plan](#)
- ◆ [Determining amount of supplementation](#)
- ◆ [Qualifications of service providers](#)
- ◆ [Determining reasonable charges](#)
- ◆ [Agreements for service](#)

### **Available Services**

**Legal reference:** 441 IAC 177.3(249)

The in-home health-related care program includes both skilled and personal care services, as follows:

- ◆ Skilled services which are necessary for the client may include, but are not limited to:
  - Gavage feedings (tube feeding of person unable to eat solid food).
  - Intravenous therapy administered only by a registered nurse.
  - Intramuscular injections, if they are required more than once or twice a week (excluding diabetes).
  - Catheterizations, including continuing care of in dwelling catheters with supervision of irrigations and changing of Foley catheter when required.
  - Inhalation therapy.
  - Care of decubiti and other ulcerated areas, noting and reporting to physician.
  - Rehabilitation services, which include, but are not limited to: bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, teaching the activities of daily living, respiratory care and breathing programs, remotivation, and behavior modification.

- Tracheotomy care.
  - Colostomy care, until the person is capable of maintaining the colostomy personally.
  - Care of medical conditions out of control, including brittle diabetes and terminal conditions.
  - Post-surgical nursing care for short time periods, primarily for persons with complications following surgery, or with the need for frequent dressing changes.
  - Monitoring medications when there is a need for close supervision of medications because of fluctuating physical or mental conditions, such as hypertensives, digitalis preparations, or narcotics.
  - Need for therapeutic diets. Evaluation of diet at frequent intervals.
  - Recording and reporting change in vital signs to the attending physician.
- ♦ Personal care services may include, but are not limited to:
- Supervision on a 24-hour basis for physical or emotional needs. This may include the use of volunteers or non-paid family, as well as the service provider, but only the cost of the health care provider will be included.
  - Helping client with bath, shampoo, and oral hygiene.
  - Helping client with toileting.
  - Helping client in and out of bed and with ambulation.
  - Helping client to reestablish activities of daily living.
  - Assisting with oral medications.
  - Performing incidental household services that are essential to the client's health care at home and are necessary to prevent or postpone facility care.

Other technical procedures may be assigned at the discretion of the supervising registered nurse, based on evaluation of the training, experience, and ability of the provider.



### **Health Care Plan**

**Legal reference:** 441 IAC 177.6(249), 441 IAC 177.10(249)

The nurse will complete a health care plan with the physician's approval. The health care plan will include the specific types of services required, the method of providing those services, and the expected duration of the services.

The nurse is responsible for assuring that the medical records in the health care plan include the following items whenever appropriate:

- ◆ Transfer forms
- ◆ Physician's certification and orders
- ◆ Progress notes
- ◆ Drug administration records
- ◆ Treatment records
- ◆ Incident reports
- ◆ Emergency instructions

The nurse will obtain from the client's physician either the physician's plan of treatment or the *Physician's Report*, form 470-0673, found in [16-J-Appendix](#). This plan will include the physician's certification that the client's health care needs can be met adequately in an in-home setting, the specific types of service required, the method of providing those services, and the expected duration of services.

A plan for the provider to follow shall be maintained in the client's home. Other medical records shall be located in the nurse's case file, with a copy of the physician's plan of services in your case file. You have the right to review all medical records.

The nurse will complete written instructions for dealing with emergency situations. These will be included in the health care plan and maintained in the client's home in the service record. The instructions will include:

- ◆ The name and telephone number of the client's:
  - Physician.
  - Nurse.
  - Responsible family members or other significant person.
  - Service worker.
- ◆ Information as to which hospital to use.
- ◆ Information as to ambulance service or other emergency transportation to use.

### **Individual Client Case Plan**

**Legal reference:** 441 IAC 130.7(234)

Develop an individual client case plan using form 470-0583, *Individual Client Case Plan*. Include in the plan:

- ♦ **Assessment:** Include a summary of the client's current home situation, natural supports, need for services, and other services the client is currently receiving.
- ♦ **Financial Eligibility:** Note the reasons the client is financially eligible.
- ♦ **Goals:** List the goals of the plan.
- ♦ **Objectives:** List the objectives of the plan.
- ♦ **Specific Services:** List the specific services the client will be receiving through the In-Home Health-Related Care (IHHRC) program.
- ♦ **Responsibilities:** List the responsibilities of the client, provider, physician, supervising nurse, and the Department of Human Services' social worker.
- ♦ **Reassessment/Termination:** Note if this is a reassessment or termination. If reassessment, update the information above. If termination, explain the reason for termination.

The health care plan is only part of the total assessment of the person's need for services. The individual client case plan should include a comprehensive outline of all service needs and plans for meeting those needs. When preparing the plan, take into consideration:

- ♦ Whether needed services can be met through existing programs including, but not limited to:
  - Homemaker-home health aide programs
  - Visiting nurse services
  - Waiver programs
- ♦ That the cost of service paid for under this program cannot exceed the base SSI allowance plus the service cost.

NOTE: You are responsible for determining if the needed services can be met through programs other than in-home health-related care. Do not use this program in place of valid referrals for homemaker, a waiver service, etc.

### **Amount of Supplementation**

**Legal reference:** 441 IAC 51.2(249)

You determine the person's services and the cost of services. The Department's income maintenance (IM) worker determines financial eligibility and the amount of client participation in the service cost. When the IM worker has transmitted that information to you, then you can determine the maximum dollar amount per month the client is eligible to receive on this program.

The amount of supplementation is the difference between the cost of the service and the amount of client participation, up to the current maximum cost per month for each person needing care. The costs must be justified by the service plan.

**The current maximum payment per month is \$480.55.**

The IM worker determines eligibility based on the family's gross income. After eligibility is determined, the IM worker considers all income available to the client in determining client participation, with applicable disregards. Some of these disregards are:

- ◆ The amount of the basic SSI income standard for an individual or a couple in their own home and for any dependents. Currently, these amounts are:
  - For an individual \$637.00
  - For a couple \$956.00
  - For each dependent, add \$319.00
- ◆ When income is earned, \$65 plus one-half of the remainder.
- ◆ Diversion for established unmet medical needs of the client, the spouse, and any dependents.

"Established unmet medical needs" include costs such as visits to physicians, prescription medicines, and related travel expenses needed on an ongoing basis and not covered by insurance or Medicaid. Insurance premiums and unmet past bills are not included.

Any income remaining after the disregards is applied toward service costs under this program before beginning supplementation. See 6-B, [IN-HOME HEALTH-RELATED CARE](#), for a complete discussion of income eligibility and client participation policies for adults and children.

Then the potential supplementation is figured up to the maximum service cost.

1. Mr. A has unearned income (SS, VA, etc.) totaling \$800 per month and unmet medical needs of \$70 per month. He must pay the first \$93 of service  $[(\$800 - \$70) - \$637]$ . No supplementation is available to Mr. A if his total service need is \$93 or less.
2. Mr. and Mrs. B have unearned income (SS, VA, etc.) totaling \$1,000 per month, with no unmet medical needs. They must pay the first \$44 of service costs  $(\$1,000 - \$956)$ . No supplementation is available to Mr. and Mrs. B if their total service need is \$44 or less.
3. Mr. and Mrs. C have earned income only of \$2,200 gross per month and unmet medical needs of \$50. Only Mr. C needs care. The first \$65 earned income is disregarded plus half of the remainder. The couple's adjusted monthly income is \$1,067.50  $[(\$2,200 - \$65) \div 2]$ . They must pay the first \$61.50 of service  $[(\$1,067.50 - \$50) - \$956]$ . No supplementation is available to Mr. C if his total service need is \$61.50 or less.

If the first month of service for a person receiving in-home health-related care is less than a full month, there is no required client participation for that month. The program will pay for the actual days of service provided according to the agreed-upon rate.

Once approved, in-home health-related care may be paid from the date of application or the date all eligibility requirements are met and qualified health care services are provided, whichever is later.

"Qualified health care services" are health care services supervised by a registered nurse and approved by a physician.

### **Qualifications of Service Providers**

**Legal reference:** 441 IAC 177.5(249)

You may assist in locating a provider. However, the primary responsibility for locating a provider is with the client or the client's family.

All providers of service under this program must meet the following criteria:

- ◆ The provider shall be at least 18 years of age.
- ◆ The provider shall obtain a physician's report on form 470-0672, Provider Health Assessment (as found in 16-J-Appendix), at the beginning of the service and yearly thereafter. This form can also be printed off the Department's web page: <http://www.dhs.state.ia.us/>. Under "Frequently Visited Links," click on "DHS Forms," then scroll down to "In Home Health Related Care Providers."
- ◆ Providers shall have the training and experience necessary to carry out the health care plan. The registered nurse supervising the case plan approves the provider's training and experience. The Department assumes no liability for the actions of any of the providers, professional or nonprofessional.
- ◆ The provider may be related to the client, as long as the provider is not a member of the family. "Family" means:
  - Legal spouses (including common law) who reside in the same household.
  - Natural or adoptive parents and children who reside in the same household.
  - A person who lives alone or with persons other than a spouse or minor child.
  - A child or minor siblings who live with a person that is not legally responsible for their support.
- ◆ A temporary absence does not change the composition of the family. When adults other than spouses reside together, each is considered a separate family.

### **Reasonable Charges**

**Legal reference:** 441 IAC 177.8(249)

Determine reasonable charges for payment of in-home health-related care service by:

- ◆ Prevailing (usual and customary) community standards for cost of similar services.
- ◆ Availability of service providers at no cost to the Department.

### **Agreements for Service**

**Legal reference:** 441 IAC 177.9(249) and 177.4(9)

Ensure that the client and each provider of in-home health care negotiate a *Provider Agreement*, form 470-0636, as found in [16-J-Appendix](#) and Outlook, before provision of service. The *Provider Agreement* includes a statement of the work to be performed, the rate of payment, and the maximum monthly payment allowed.

Discuss with providers (individuals and agencies) their responsibilities and liabilities, including discontinuance of payment upon termination of service.

The provider of services under this contract is not an agent, employee, or servant of the state of Iowa, the Department of Human Services, or any of its employees. It is the provider's responsibility to determine employment status in regards to income tax and social security. Providers of service have no recourse to the Department to collect payments due as a result of this agreement.

Discuss the termination procedures and time limits with the client and the provider.

Assign a number for each *Provider Agreement*. The numbering system consists of provider agreement identifier (31), a two-digit county number, and a three-digit individual agreement identifier (example: 31-01-001). If a county has more agreements than can be accommodated with this numbering series, the numbers are repeated with a 32, 33, or 34 designation replacing 31, as needed.

Every client must have a *Provider Agreement* with every provider that the client has. A provider that has more than one client must have a different *Provider Agreement* for each client. Every *Provider Agreement* must have a different provider agreement number. Therefore, a client and a provider could each have more than one valid *Provider Agreement*, each with different numbers.

Enter each provider agreement in the *Services Reporting System*, by completing form 470-0555, and on the POSS System. (See [Entering Agreements on POSS.](#))

To change anything on a *Provider Agreement*, fill in a new form and check "Amendment." See [MONITORING AND CHANGING SERVICES: Amending Agreement.](#)

### **Requesting Certification**

**Legal reference:** 441 IAC 177.4(5)

Your service area manager (or designee) certifies the in-home health-related care service program by signing the form 470-0583, *Individual Client Case Plan*. Send to your service area manager (or designee) the following:

- ◆ A copy of the total form 470-0583, *Individual Client Case Plan*, including the health care plan.
- ◆ Three copies of the *Provider Agreement*, form 470-0636.

The signed form 470-0583, *Individual Client Case Plan*, returned to you constitutes certification and approval for payment.

Your service area manager (or designee) will return the plan and three copies of the signed *Provider Agreement*. Distribute one copy of the *Provider Agreement* to the client, one to the provider, and one to the case file. Enter the *Provider Agreement* on the POSS System. (See [Processing Payments.](#))

When the agreement is approved, give each provider an adequate supply of form 470-0648, *Statement of Services Rendered*, with self-addressed stamped envelopes to mail to you at the end of each month.

More information is included in the following sections:

- ◆ [Notification](#)
- ◆ [Denial of service](#)
- ◆ [Eligibility for Medicaid](#)

### **Notification**

**Legal reference:** 441 IAC 7.7(1)

Notify the client of approval, denial, or termination of service and when changes occur, using form 470-0602, *Notice of Decision: Services*, as found in [16-J-Appendix](#) or Outlook. Include in the *Notice of Decision: Services*:

- ◆ A statement of what action is being taken.
- ◆ The reasons for the intended action.
- ◆ The manual chapter number and subheading supporting the action, along with the Iowa Administrative Code reference.
- ◆ The amount of client participation, if any

Send the IM worker a copy of the *Notice of Decision*, form 470-0602, with the completed *Service Report*, form 470-0506. Inform the IM worker of:

- ◆ Approval and certification of case plan.
- ◆ The maximum amount of payment approved.

### **Denial of Service**

**Legal reference:** 441 IAC 51, 177

If the client is ineligible to receive State Supplementary Assistance because the income or resources exceed the program maximum limits, the IM worker denies the application and sends form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, to the client.

You deny the application and send form 470-0602, *Notice of Decision: Services*, when:

- ◆ The client is ineligible because the client participation exceeds the cost of care. The client does not need supplementation to meet the cost of care.
- ◆ The physician does not approve the in-home health care plan.
- ◆ An appropriate provider cannot be located within 60 days from the date of application.
- ◆ Other programs or services available in the community needs can meet the client's needs.



### **Eligibility for Medicaid**

**Legal reference:** 441 IAC 75(9)

Most recipients of State Supplementary Assistance are eligible for Medicaid. (Medicaid has eligibility factors not common to SSI or State Supplementary Assistance.) The IM worker makes that determination. Eligibility is redetermined at least annually. When the client is eligible for Medicaid, the IM worker:

- ♦ Sends form, 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, to the client indicating the eligibility.
- ♦ Issues a *Medical Assistance Eligibility Card*. Medicaid eligibility begins the first day of the month when service begins.

A client who becomes eligible for Medicaid due to receipt of State Supplementary Assistance may be eligible for Medicaid retroactively for up to three months. To apply for retroactive assistance, the client informs the IM worker that there are unpaid bills. The IM worker determines retroactive eligibility.

**Never** approve a client to receive in-home health-related care solely for the purpose of obtaining Medicaid coverage.

### **Processing Payments**

**Legal reference:** 441 IAC 177.4(9)

POSS, the Purchase of Service System, is the computer system that provides the means to enter information from the *Provider Agreement* and the *Purchase of Service Invoice* and generate payment for in-home health related care services. Information entered in the Service Reporting System (SRS) must be accurate and must agree with information that you enter in POSS.

At the end of each month, the provider completes form 470-0648, *Statement of Services Rendered*, and submits it to you.

Complete the *Purchase of Service Provider Invoice*, form 470-0020, for all in-home health-care providers that have submitted a signed *Statement of Services Rendered*. Complete only one invoice per month for each agreement.

You may **not** enter an invoice until **after** the month is over. The first day you may enter an invoice is the first day of the following month.

Assign the client for whom payment is due to the indicated county. Enter the provider agreement data on the odd-numbered lines. Enter the client payment data on the even-numbered lines. The client is the sole payee for payments made under this program. The client is responsible for making payment to the provider, except when either of the following circumstances applies:

- ◆ The client has a person legally designated to handle finances, such as a:
  - Conservator
  - Representative payee
  - Power of attorney
- ◆ One payment may be made to the provider on behalf of a client who dies or becomes incapacitated while receiving services.

NOTE: To be sure there are no problems in getting an invoice paid, submit all agreement information on line and complete SRS at least two weeks before entering the invoice in on line.

After entering the invoice information on the POSS Invoice screen, attach the *Statement of Services Rendered* to the *Purchase of Service Provider Invoice*. Maintain the original invoices in the local office for the current fiscal year plus the next fiscal year. Invoices may then be sent to record storage for an additional nine years using reference # BUD 2-10-1, Accounts Payable Records. (Records Management Manual, Records Retention and Disposition Schedule BUD.)

The Department of Administrative Services writes checks after each weekly payment run. The Bureau of Purchasing, Payments and Receipts usually mails checks for invoices received by Monday of each week by the following Friday.

The following sections provide additional information on:

- ◆ [Accessing the POSS system](#)
- ◆ [Entering agreements on the POSP screen of POSS](#)
- ◆ [Entering invoices on the POSI screen of the POSS system](#)
- ◆ [Corrections](#)
- ◆ [Department-authorized reductions in payments](#)
- ◆ [Payments directly deposited into client's bank account](#)
- ◆ [Warrant returns](#)
- ◆ [Clients who are dead or incapacitated when the payment is issued](#)

### **Accessing POSS**

Access POSS (Purchase of Service System) through the Extra program in your desktop computer. After opening Extra, enter the system through NES, the Network Entry System. Enter your user ID and your password. Enter X on the line that states Production on CICS.

When Production on CICS appears, press enter. The next screen states, "Type a transaction ID or help and press enter." Press the pause key on your keyboard. A blank screen will appear. Type "POSS," press ENTER, and the Purchase of Service Menu appears. The Purchase of Service Menu gives you access to:

- ◆ The Provider Agreement screen, listed as POSP, and
- ◆ The client's eligibility history, listed as POSE
- ◆ The Invoice Display, listed as POSI.
- ◆ The payment history, listed as POSH

To access a client's eligibility history, place an X to left of menu entry POSH ELIGIBILITY DATA, then press ENTER. The cursor will go to CASE #. Enter the case number and press ENTER. The eligibility data entered on the client in the SRS will be displayed.

To access a client's payment history, place an X to left of menu entry POSH PAYMENT HISTORY, then press ENTER. The cursor will go to CASE #. Enter the case number and press ENTER. The complete payment history of the client will be displayed for all services paid by the POSS program.

## **Entering Agreements on POSS**

To enter a provider agreement, sign on to POSS in the mainframe computer system. Place X to left of menu entry designated POSP, then press <ENTER>. On the command line, enter action code A to add a provider agreement. Enter the seven-digit *Provider Agreement* number after PROV #, and press <ENTER>. You do not need to enter the service code. This will bring up the POSP add screen:

POSP ADDS		PURCHASE OF SERVICE PROVIDER DATA FOR				TODAYS DATE 11/04/94			
PAYEE NAME: ??????????????????					PROVIDER NAME: ??????????????????				
ADDR: ?????????????????? ????????????????????					CASE NUMBER: ??????????				
CITY/STATE: ??????????????					CLIENT'S NAME: ??????????????				
ZIP: ???? ???									
VEND CODE/LOC/TYPE/CODE TYPE: ??????? ? ? ?					TAX-EXEMPT: ?		OUT OF STATE: ?		
SERVICE INFORMATION									
SERV CODE	UNIT TYPE	EFFC DATE	TERM DATE	SERV RATE	SERV CODE	UNIT TYPE	EFFC DATE	TERM DATE	SERV RATE
???	?	?????	?????	?????????	???	?	?????	?????	?????????
???	?	?????	?????	?????????	???	?	?????	?????	?????????
???	?	?????	?????	?????????	???	?	?????	?????	?????????
???	?	?????	?????	?????????	???	?	?????	?????	?????????
???	?	?????	?????	?????????	???	?	?????	?????	?????????
ENTER AN 'A' IF MORE SERVICES, 'C' TO CANCEL ENTIRE ENTRY									
ACTION: A		INV #:		CASE #:		PROV #:		0 SERV CD:	
NAME:		REGN:		CNTY:		FUND:		FY: SCR N: POSP	
CLEAR = END SESS			PF1 = MAIN MENU			PF9 = HELP			
MESSAGES: HIGHLIGHTED FIELDS IN ERROR - PLEASE CORRECT AND DEPRESS ENTER									

Enter provider agreements as follows:

<b><u>POSP Fields</u></b>	<b><u>Valid Entries</u></b>
Payee Name	Enter up to 24 characters of the payee's name, last name first, then first name. The way the name is entered here determines how it is entered on the invoice. There is no need to use upper-case and lower-case letters. Question marks remaining after completed name do not need to be removed.
Addr	Enter up to 42 characters of the payee's street address. This address will be used to mail warrants. There is no need to use upper-case and lower-case letters. Question marks remaining after the address is entered do not need to be removed. This entry can be changed but not deleted.
City/State	<p>The city/state is used on the warrant. This field holds up to 16 characters. If the city name is more than 14 characters, reduce it to 14 so the state can be entered. The state must be the official two-letter abbreviation (Example: Iowa = IA).</p> <p>There is no need to use upper case and lower case letters. Question marks remaining after city/state is entered do not need to be removed. This entry can be changed but not deleted.</p>
ZIP	The zip code is used to mail warrants. Entry is needed only of the five-digit ZIP code. It can be changed but not deleted.
Provider Name	Enter up to 24 characters of the provider's name.
Case Number	Enter the client's 11-digit SRS case number.
Client's Name	Leave blank. The system automatically defaults to the client's name when the SRS number is entered.
Vendor Code	This is always the client's nine-digit social security number. This field <b>must</b> be completed. It can be changed but not deleted.
Vendor Location	"00" is automatically generated.

<b><u>POSP Fields</u></b>	<b><u>Valid Entries</u></b>
Vendor Type	One character. (This entry can be changed but not deleted.)  I Individual S Sole proprietorship C Corporation P Partnership E Estate or trust U Public service corporation G Government O Other
Vendor Code Type	System-generated. Never entered.
Out-of-State	One-character code, for agency providers only. Enter 'Y' if an agency provider is out of state. Enter 'N' to change Yes to No. Leave blank for in-state providers. This entry can be changed or deleted.
Serv Code	The service code will be displayed as 9801.
Unit Type	Enter the one-digit code for the unit of service. This entry can be changed but not deleted. (Be sure to enter action code "C" before making changes.) Valid codes are:  1 1/2 hour 2 Hourly 3 1/2 day 4 Day 5 Monthly 6 Session/job 7 Trip 8 Mile 9 Meal (week)
Effc Date	Enter the six-digit beginning date for the service or rate, in month/day/year order. This entry can be changed but not deleted. (Be sure to enter action code "C" before making changes.) Valid entries are:  Month 01-12 Day 01-31 Year numeric

**POSP Fields**

**Valid Entries**

Term Date

Do not enter the service or rate ending date on a new provider.

When a new effective date or rate is added to an existing service, enter a termination date for the old rate or service one day before the new effective date. Enter the six-digit date in month/day/year order. This date can be changed or deleted.

Serv Rate

Enter the service rate in dollars and cents. The system allows nine digits for cost of a unit of service: seven digits for dollars and two digits for cents. The system automatically generates a decimal point to the left of the last two digits entered. Question marks remaining after rate is entered can be ignored.

This entry may be changed but not deleted. When **correcting** an entry you made, place the cursor in the left-most space of the field, delete with the delete key, and reenter.

To enter a **change** in the service rate, enter action code "C" to move the current data to history and allow a line for new entries.

Just Above the  
Command Line

Enter the one-character action code as needed:

- ◆ For more than ten services, enter an 'A' in the ACTION field (if not present) and press <ENTER>. The system will bring up another ten blank service lines.
- ◆ To enter any change on an existing screen, enter "C." This allows you to reenter provider and service data. It does not remove what was previously entered and is already on the provider master file.

### **Entering Invoices on POSS**

To enter an invoice on POSS, sign on to POSS in the Extra program on your desktop computer. Place X to left of menu screen designated POSI, then press <ENTER>.

On the Command Line:

1. Enter code A next to ACTION.
2. Skip INV#.
3. Enter the seven-digit *Provider Agreement* number after PROV #.
4. Add last three letters of the payee's name.
5. Then press <ENTER>.

You do not need to enter the service code. This will bring up the POSI add screen.

POSI	PURCHASE OF SERVICE INVOICE				TODAYS DATE		
				PAGE			
BILLING DATE: ??????????????		STATE/LOCAL: ?		COUNTY NUMBER/NAME			???????
AGREEMENT #:		PROVIDER NAME:					
ACT	CASE#	LAST NAME	FIRST NAME	MID NAME	SERV	BEG SERV	END SERV
LINE#	UNIT COST	UNITS	TOTAL COST	FEES	CREDITS	NET COST	E01
????????????????? ??							?????
0101	?????????????????	????????????	????????????	????????????	????????????	????????	
ACTION: INV #:		CASE #:		PROV #:		SERV CD:	
NAME:		REGN:		CNTY: FUND:		FY: SCR N: POSI	
CLEAR = END SESS				PF1 = MAIN MENU			
MESSAGES: ENTER APPROPRIATE FIELDS							



Enter invoices as follows:

<b><u>POSI Fields</u></b>	<b><u>Valid Entries</u></b>
Billing Date	Enter the first date of the billing period, such as 10-1-00.
State/Local	Enter S
County Number/Name	Enter the number of the county with zero as the first of the three numbers and first three letters of the name of the county, such as 077 POL.
Case#	Enter the eleven-digit SRS case number.
Last Name	Enter the first three letters of last name of client. Tab to SERV BEG.
Serv Beg	Enter a date only for the first month of service.
Unit	Enter the unit cost.
Total Cost	Enter the total cost.
Fees	Enter the amount of fees.
Credits	Enter any credits, then press <ENTER>.

NOTE: You **may not enter** an invoice until **after** the month is over. The first day you may enter an invoice is the first day of the following month.

### **Corrections**

Whenever payments for one or more clients are rejected, you must correct the incorrect data and enter the unpaid portion of the invoice. During the correction process, first check each case to determine whether the item that caused the exception was entered correctly on the on-line invoice screen.

Reenter the information on the on-line invoice screen.

Following is the list of exception conditions for cases that were rejected by the automated system.

<b>Code</b>	<b>Error Description</b>
01	Client name on invoice does not match the client name on the Service Reporting System (SRS) for the client's case number.
02	Eligibility. The matching case for the indicated number is not on the SRS. If the case number is correct, enter the case into the SRS; otherwise, correct the case number. The claim must then be resubmitted on a new invoice.
03	Eligibility. The matching service for the indicated number is not in the SRS. If the service code is correct, enter the service into the SRS; otherwise, correct the service code. The claim must then be resubmitted on a new invoice.
04	Eligibility. The billing date (billing period of service beginning date) for the case either precedes the effective date on the SRS or exceeds the termination date on the SRS; or the provider number does not match the SRS provider number. If the date and provider number on the invoice are correct, make the correction in the SRS. The claim must be resubmitted on a new invoice.
06	Duplicate. A payment was made previously for this case during the given billing period. Recheck the case number, service code, and billing date. If any of these is incorrect, make the correction and resubmit the claim on a new invoice.
07	Duplicate. A billing for the same case, service, and billing period was submitted on the same payment run. Check to see if the other billing was paid by the system. If not, resubmit on a new invoice.
08	Net cost. The net cost does not agree with the amount calculated from unit code, number of units, and credits. Recheck totals and resubmit on a new invoice.
10	State/local code. All invoices for in-home health-related care must show state/local code "S."

<b>Code</b>	<b>Error Description</b>
12	Account code. The account code is determined from the basis of eligibility, funding, and service code. If any of these items are incorrect, central office will make the accounting correction, but the case must still be resubmitted on a new invoice. The basis of eligibility is obtained from the SRS.
13	Eligibility. 9099 and 9899 are not valid eligibility codes. The eligibility basis may be determined from the SRS manual. Correct the eligibility data in the SRS before resubmitting the billing on a new invoice.
14	Agreement. An agreement for the number indicated is not in the system. If the agreement number is incorrect, correct the number and resubmit the claim on a new invoice. Otherwise, an agreement must be on file and in the system before payments can be processed.
15	Agreement. The name as entered on the invoice does not match the name in the system. Be sure the client's name is entered on the invoice as it appears on the agreement. If incorrect, resubmit on a new invoice.
16	Agreement. The rate for the indicated service is not in the system. If the service code is correct, the rate for this service must be established and in the system so that payments can be processed. After corrections are made, the claim must be resubmitted.
17	Agreement. The billing date for this service either precedes the agreement effective date or exceeds the termination date. If the date on the invoice is correct and a rate is established, central office enters the rate. The claim must then be resubmitted on a new invoice.
18	Agreement. The rate as entered on the invoice exceeds that in the agreement. If the rate in the system is incorrect, it is corrected by central office, but the claim must be resubmitted on a new invoice.
19	Invoice. The invoice contains a billing date that is not in the same fiscal year that we are processing for.

### **Department-Authorized Reduction**

When the Department authorizes a payment reduction, have the provider and client complete the *Amendment to Provider Agreement*, form 470-1999, found in [16-J-Appendix](#). This will verify that they have been made aware that the payment will be reduced.

### **Direct Deposit of Payments into Client's Bank Account**

A client who wishes to have the in-home health-related care payment deposited directly into a bank account must complete a form and submit it to the Iowa Department of Administrative Services. A copy of the form is available on the DHS network at:

Hoovr3s2: Payments: Payment Instructions & Forms: EFT Authorization.doc

You may print off this form and provide it to clients who wish to have their in-home health-related care payment directly deposited into a bank account. The form contains instructions on where to mail or fax the completed form.

### **Warrant Returns**

Any warrants returned to the Department's central office from the client will be kept in the Bureau of Purchasing, Payments, and Receipts until you can verify the address. When the address is verified, the Bureau will mail the warrant again.

If the warrant could not be delivered due to incorrect information on the *Provider Agreement*, correct the information with an amendment to the agreement. (Examples: new address, deceased client, or incorrect SRS number.) Then enter the corrected information on line on the provider screen before entering the next invoice.

### **Client Dead or Incapacitated**

**Legal reference:** 441 IAC 177.4(9)

When a client dies or becomes incapacitated:

1. Complete an amended *Provider Agreement* reflecting the client's changed condition and listing the provider as the payee.
2. Complete an amended invoice reflecting the client's changed condition and listing the provider as the payee.

NOTE: If a warrant was issued to the client, attach it to the amended agreement and invoice. This is a one-time only procedure. If an incapacitated client will remain in the program, assist the client's family to have a person legally designated to handle the client's finances and become payee on behalf of the client.

### **Monitoring and Changing Services**

**Legal reference:** 441 IAC 177.6(3) and 441 50.4(2)

Review the continuing need for in-home health-related care service periodically, as follows:

♦ **At least every 60 days:**

- The physician shall review and recertify the appropriateness of the health care plan.
- The nurse shall review the nursing plan.
- The nurse shall provide an updated copy of the physician's health care plan and the nursing plan of care to the provider.

- ♦ **At three months:** Review the total care plan at least every three months. This can be done by a phone contact to someone involved with the care plan, such as the provider or nurse. NOTE: You, the physician, or the nurse may require more frequent reviews.

♦ **Annually:** Review and write a new case plan annually. At that time:

- Assist the client in completing and signing form 470-3118 or 470-3118(S) *Medicaid Review*. This form is automatically sent to the client. This form serves the same function as the *Application for All Social Services*, form 470-0615 or 470-0615(S).
- Send the completed *Medicaid Review* to the IM worker. The *Medicaid Review* will be maintained in the IM case file. You do not need a copy.
- Have the provider complete a new *Provider Health Assessment*, form 470-0672.
- Request an updated *Physician's Report*, form 470-0673, and nursing plan of care for your records.

### **Amending Agreement**

To change anything on the *Provider Agreement*, form 470-0636, (other than client and provider name) fill out a new form, but check "amendment." Duties do not need to be repeated. The agreement number remains the same.

NOTE: You cannot change clients or providers with an amendment. There must be a new *Provider Agreement*, for a new client or a new provider with a different provider agreement number. If a provider has more than one client, the provider must have a different *Provider Agreement* for every client. Therefore, a client and a provider could each have more than one valid *Provider Agreement*, each with different numbers.

You may use form 470-0636 to change any item on an established agreement except for a new client name, or new provider name, or a new service code. When one of these exceptions changes, a new *Agreement* must be completed, with a new agreement number.

When a client dies or becomes incapacitated while receiving service and the client is the payee, you may file an amendment listing the provider as payee. See [Client Dead or Incapacitated](#).

The instructions are the same for each line item as those for the agreement.

If you make a change in the top section of the form, complete all items in both sections, enter the agreement number, and check "yes" for amendment.

- ◆ The following items may be amended with no client or provider signature:
  - Addresses and phone numbers.
  - Incorrect case number or social security number.
  - Maximum per month DHS, if it is increased.
  - Addition of or change in a payee.
  - Unit cost, if increased.
  - Termination date, if the client has requested termination, has died, or has entered a long-term care facility.
- ◆ The following amendments require client and provider signatures:
  - Decrease in unit cost.
  - Change in type of unit, for example: from hourly to monthly.
  - Decrease in maximum per month DHS.
  - Maximum per month client.
  - Termination date that is adverse to the client. (Death or client move out of home does not require signature.)
  - Renewal of agreement for the next time period. (List new beginning and termination dates.)

Send the agreement amendments to the service area manager (or designee) for signature. When you have the signed *Provider Agreement* returned from the service area manager (or designee), enter the changes on the POSS System. (To get the change screen, use action code C, for change, and enter the provider number.)

### **Adding or Changing Providers**

When a new provider begins:

1. Explain the billing procedures, responsibilities, and limitations of the program to the new provider.
2. Give the provider form 470-0672, *Provider Health Assessment*, to be completed by a physician.
3. Complete the new *Provider Agreement*, form 470-0636, with the new provider and the client.
4. Mail all copies of the *Provider Agreement* to the service area manager (or designee) for approval.
5. When the service area manager (or designee) returns three copies of the signed *Provider Agreement*, file one copy and mail one each to the client and the provider. Before sending copies of the *Provider Agreement* to the client and provider, use a black marker pen to delete the client's social security number.
6. Give the new provider an adequate supply of form 470-0648, *Statement of Services Rendered*, and self-addressed stamped envelopes to mail to you at the end of each month.
7. Notify the supervising nurse of the new provider and change the name of the provider on the case plan.
8. Add another B98 (with beginning date and agreement number) on the SRS.
9. Enter the new agreement on POSS.



When a *Provider Agreement* is canceled before the expiration date:

1. Submit an amendment to the person who enters data in your office, changing the end date in the bottom section.
  - ◆ Complete agreement number and check yes for "amendment."
  - ◆ Enter the client name, and all items in the bottom section, including the service code, unit, start and end dates, unit cost, and maximum per month for DHS and for the client.
2. When the old provider has received the last payment, remove the old B98 entry from the SRS.
3. Enter a termination date on the POSP screen to show that this is no longer a valid provider agreement.

To delete the provider:

1. Select the POSP screen.
2. In the action field, enter "D" and the provider number. The system will ask you to re-enter the provider number and service code.
3. Enter the provider number and B98 and press "enter."

### **Terminating Services**

**Legal reference:** 441 IAC 177.11 (249)

Terminate in-home health-related care service under the following conditions:

- ◆ Upon the request of the client or legal representative. When termination of the program would result in the client being unable to protect the client's own interests, provide arrangements for guardianship, commitment, or other protective placements.
- ◆ When the client becomes sufficiently self-sustaining to remain in the client's own home with services that can be provided by existing community agencies.
- ◆ When the physical or mental condition of the client requires more care than can be adequately provided by this program in the client's own home.

- ◆ When cost of care needed for the client exceeds the maximum established in the determination of the supplementation.
- ◆ When you determine that other services can meet the client's needs better.
- ◆ You determine that either the client or the provider has not met the terms of the *Provider Agreement*, form 470-0636. For example when the provider has failed to perform the duties listed or the client has failed to pay client participation.
- ◆ When you receive a *Notice of Decision* from income maintenance that the client is no longer financially eligible.

The following sections give more information on:

- ◆ [When the client is absent from home for more than 15 days](#)
- ◆ [Termination procedures](#)
- ◆ [Appeals](#)

### **Client Absent From Home for More Than 15 Days**

Allow the client to remain eligible and make payment for services for no more than 15 days in any calendar month when the client is absent from home for a temporary period. Do not authorize payment for over 15 days of continuous absence, whether or not the absence extends into a succeeding month or months.

As soon you know that the out-of-home stay will exceed 15 days, tell the income maintenance worker to send a termination notice to the client. Also notify the nurse and the provider.

### **Termination Procedures**

When you terminate IHHRC services, use the following procedures:

1. Notify the client of the termination on form 470-0602, *Notice of Decision: Services*, allowing timely and adequate notice except as described in 1-E, [Dispensing with Timely Notice](#). **Always** send a copy to the income maintenance worker.

EXCEPTION: When income maintenance has terminated IHHRC benefits due to the client no longer being financially eligible, **do not** send a *Notice of Decision*. Income maintenance will send you a copy of their notice. You can use that in your case file as the notice of termination.

2. Notify the nurse and the provider of the termination of service.
3. Continue payment during the ten-day notice period if service is provided during that time. For situations not requiring timely notice, payment shall be stopped immediately upon the date of the termination notice.
4. Enter a termination date for the *Provider Agreement* from the POSS system after the last claims are paid.
5. Delete the provider as follows:
  - ◆ Select the POSP screen.
  - ◆ In the action field, enter "D" and the provider number. The system will ask you to re-enter the provider number and service code.
  - ◆ Enter the provider number and B98 and press "enter."
6. Delete the client as follows:
  - ◆ Select the POSE screen.
  - ◆ Enter "D" in the action field.
  - ◆ Enter the case number and press "enter."

## **Appeals**

**Legal reference:** 441 IAC 7.6(217)

Advise each applicant and recipient of the right to appeal any adverse action affecting the person's status. Assist in the filing process as needed.

If you receive an appeal, immediately complete Part II of form 470-0487, *Appeal and Request for Hearing*. Send it, the written appeal, and a copy of the notice that the client is appealing to the Appeals Section within one day of receiving the appeal request.

Forward a summary and supporting documentation for your action to the Appeals Section within 10 days of receiving the appeal request. Send a copy to the client and the client's representative, if any.

Note: Follow the appeal processes outlined in Employees' Manual 1-E, [APPEALS AND HEARING](#)